February 3, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0423-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on ___ external review panel. This physician is board certified in anesthesiology. ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 40 year-old female who sustained a work related injury on ___. The patient reports that while at work on ___ she was lifting boxes and she suddenly experienced shaking in her legs. The patient reported low back pain and was unable to stand up straight. The patient underwent X-Rays, MRI, lumbar myelogram, lumbar discogram, and an EMG. The patient has had one previous back surgery in ___. The diagnoses for this patient are lumbar discogenic disease, lumbar discogenic pain, lumbar facet syndrome, and myofascial syndrome of the back.

Requested Services

Outpatient IDET.

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

___ physician reviewer indicated that this patient has sustained a work related injury to her back on ___. ___ physician reviewer also indicated that the patient had sustained a previous back injury in ___. ___ physician reviewer noted that the patient has been treated conservatively with physical therapy, chiropractic treatments, analgesic medications, and biofeedback. ___ physician reviewer also noted the patient has been evaluated and treated by a pain management specialist. However, ___ physician reviewer further noted that the patient continues to complain of low lumbar and lumbosacral pain radiating to the left leg. ___ physician

reviewer explained that the documentation provided does not indicate that the proposed Intradiscal Electrothermal Therapy (IDET) is the only alternative treatment for this patient. ___ physician reviewer also explained that the patient's pain management specialist indicated that the patient has treatment options other than IDET. ___ physician reviewer further explained that the patient has not been evaluated by a neurosurgeon recently. ___ physician reviewer indicated that a neursurgery consultation should be performed before any procedure such as IDET. Therefore, ___ physician consultant concluded that IDET is not medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 3rd day of February 2003.